3106 Texas Ave. S.
College Station, TX 77845

Date____________________

PATIENT INFORMATION

Last Name______________________ First Name _____________________________ MI __________
Mailing Address _______________________ City_____________________________ Zip__________
Home Phone ____________________ Cell Phone ____
Office Phone ____________________ Email ____
Date of Birth ____________________ Circle one please: Male Female Other: ________________
SSN____________________________ Driver's License # _______________________

INSURANCE POLICY HOLDER INFORMATION (*If different than above*)

Last Name ________________________ First Name ____________________________ MI __________
Address ___________________________ City _________________________________ Zip __________
Home Phone ______________________ Cell Phone ____
Office Phone ______________________ Driver's License # ___________________________________
Date of Birth ______________________ SSN____

EMERGENCY CONTACT

Name __________________________ Relationship ____
Phone __________________________

MEDICAL INFORMATION

Pharmacy Name and City____
Primary Care Provider (PCP) ____
Pain Management Provider ____
Cardiologist ____
Other Specialist Provider ____

Can we contact these physicians for records? Yes No
Can we send a letter to these physicians evaluating you Yes No

REFERRAL INFORMATION

Please tell us how you were referred here by indicating below:

____ Physician Name: ________________________________

____ Another Medical Professional Name: ________________________________

____ Another Patient of Ours Name: ________________________________

____ Internet Name: ________________________________

____ Newspaper/Magazine Name: ________________________________

Patient Name: ___________________________ Date of Birth: __________________________

REASON FOR VISIT

Main Problem – Be as specific as you can. For example, “Numbness in left leg when lying down at night”

____

____

____

____

How long has this particular problem been going on? Ex: “Back pain for 5 years, numbness since March”

____

Has it been getting: Better Worse About the same

Other related problems: Please be as specific as you can. For example, “Pain in left hip.”

____

____

____

Prior to the onset of the above problems, did you feel well? Yes No

Have you received any of the following other treatments for this orthopedic problem? **Please include the provider name/ facility and the estimated date, date range, and number of visits.**

Other Spine or Neurology Specialist: ____

Chiropractic Care: ____

Physical Therapy: ____

Pain Injections: ____

Other: ____

Have you ever had X-rays, CT scans, or MRIs? If so, **when** (date) and **where** (facility)?

____

____

____

Have you ever had a Bone Density test? If so, **when** (date) and **where** (location)?

____

____

Patient Name: ___________________________ Date of Birth: __________________________

PAST MEDICAL HISTORY

Please list any medical conditions for which you are being treated. Include Diabetes, cardiac, respiratory, etc.

______________________________________ ____
______________________________________ ____
______________________________________ ____
______________________________________ ____
______________________________________ ____

PAST SURGICAL HISTORY:

Please list any surgeries that you have had.

____ Date: ______________________
____ Date: ______________________
____ Date: ______________________
____ Date: ______________________
____ Date: ______________________

MEDICATIONS

Please list all medications you take on a regular basis. Include dosage.
(Includes non-prescription drugs like Tylenol and Advil)

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

DRUG ALLERGIES

[ ] Yes (Please list below.) [ ] No known drug allergies.

____
____

FAMILY HISTORY

Is there a history of spinal disorders or surgery in your family? [ ] Yes [ ] No

If so, please list who, and the problems to the best of your recollection.

____
____

SOCIAL HISTORY

Please circle one of the following: Single Married Divorced Widowed Separated
Occupation ________________________________ Employer______________________________________
If you are retired/not working, what was your prior occupation? __________________________________

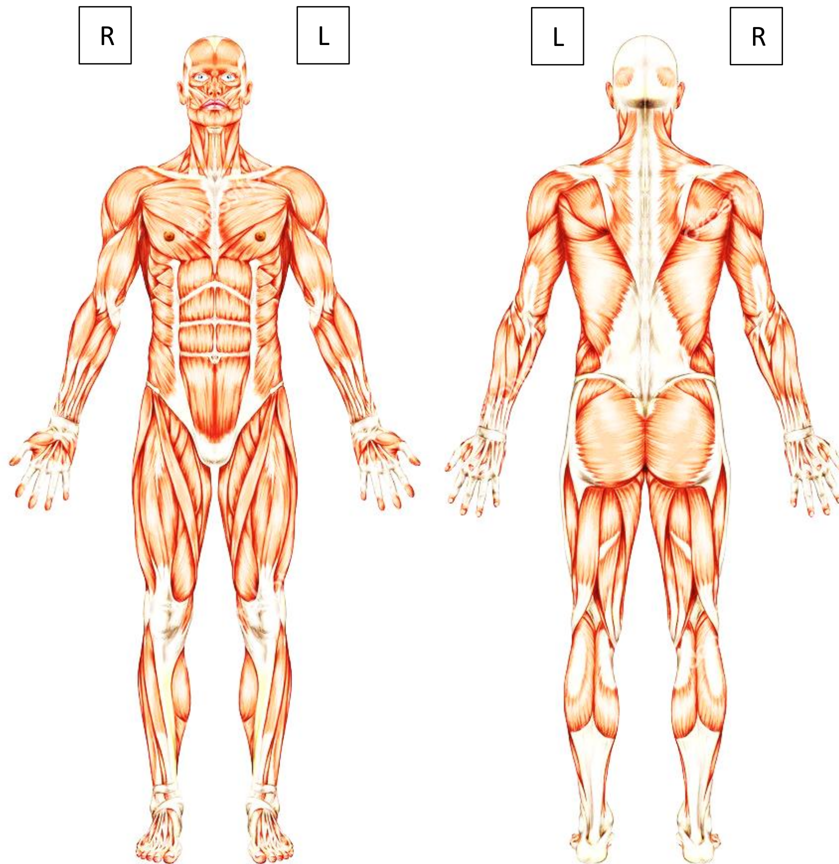
Do you:

Smoke cigarettes? _______ Vape? ______ If yes, how many per day? __________________________
Use other tobacco/nicotine products? ______ If yes, which products? ______________________________
Drink alcoholic beverages? _______________ If yes, how many per day? __________________________

Patient Name: ___________________________ Date of Birth: __________________________

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

Key: Pins and Needles = 0000 Stabbing = ////
Burning = XXXX Deep Ache = ZZZZ



Please rate your current level of pain (Circle one).

1 2 3 4 5 6 7 8 9 10

Please rate your worst level of pain in the last 24 hours (Circle one).

1 2 3 4 5 6 7 8 9 10

Please rate your best level of pain in the last 24 hours on the following scale (Circle one).

1 2 3 4 5 6 7 8 9 10

0 = No Pain 10 = Worst Pain Imaginable

REVIEW OF MEDICAL SYSTEMS & MEDICAL HISTORY

Please check if you are experiencing any of the following.

ALLERGIES
- ☐ Asthma
- ☐ Hay Fever
- ☐ Skin Eruption
- ☐ Latex Allergy
- ☐ Nickel Allergy

CARDIOVASCULAR
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins
- ☐ Chest Pain

CONSTITUTIONAL
- ☐ Chills/Sweats/Fever
- ☐ Loss of Sleep
- ☐ Weight Change

EAR/NOSE/THROAT
- ☐ Hearing Loss
- ☐ Nosebleeds
- ☐ Ringing in Ears
- ☐ Earache
- ☐ Hoarseness
- ☐ Persistent Cough
- ☐ Vertigo
- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Sinusitis

DERMATOLOGY
- ☐ Ulcers
- ☐ Change in scars/moles/skin
- ☐ Lesions or Masses
- ☐ Rashes
- ☐ Dermatitis or Eczema

EYES
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Double Vision
- ☐ Corrective Lenses
- ☐ Vision Flashes/Halos

GENITOURINARY
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Rectal Bleeding
- ☐ Abdominal

HEMATIC/LYMPHATIC
- ☐ Swollen Lymph Nodes
- ☐ Easy Skin Bruising
- ☐ Prolonged Bleeding
- ☐ Gout
- ☐ Excessive Thirst
- ☐ Anemia
- ☐ Blood Clots

NEUROLOGICAL
- ☐ Fainting
- ☐ Headache
- ☐ Numbness of arms/legs
- ☐ Seizures
- ☐ Coordination Problems
- ☐ Tingling of hands/feet/arms/legs

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Restlessness
- ☐ Nervousness

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Blood when Coughing

MUSCULOSKELETAL
- ☐ Pain, Weakness, Swelling, Numbness in:
  - _ Hands
  - _ Wrists
  - _ Hips
  - _ Knees
  - _ Arms
  - _ Legs
  - _ Joints
  - _ Back-low (lumbar)
  - _ Back-middle (thoracic)
  - _ Back – neck (cervical)

ENDOCRINE
- ☐ Pre-Diabetic
- ☐ T1 Diabetes
- ☐ T2 Diabetes
- ☐ Osteoporosis
- ☐ Osteopenia

OTHER CONDITIONS NOT LISTED:

____
____
____
____
____
____
____

AUTHORIZATION OF CARE

Patient Name: ___________________________ Date of Birth: __________________________

I grant permission to the employees of this clinic to render routine outpatient care to me and to carry out the orders of the clinic physician.

FINANCIAL AGREEMENT

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
   a. At the time of your visit, you are required to pay your copayments, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
   b. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance carrier, and the balance due is considered payable by you.
2. It is your responsibility to notify our front desk staff of any insurance or address changes.
3. Any cost incurred to collect a debt will be at the expense of the patient/responsible party.

PATIENT AUTHORIZATION

I authorize Brazos Spine to submit insurance claims using my signature on file below.

I authorize release of any medical information necessary in order to process my claims.

I authorize Brazos Spine to communicate my protected health information to me via the contact information listed on the first page. I understand this applies only to communications from the office of Mukund I. Gundanna, M.D. to the patient and to the insured of an insurance policy that covers the patient as a dependent. This will remain in effect until I notify Brazos Spine of any change.

I authorize payment of medical benefits to be paid directly to Brazos Spine for services described on the claim form submitted to the insurance company.

I authorize Brazos Spine to request any medical information necessary for continuation of my care.

I authorize Brazos Spine to release any medical or billing information necessary for treatment, payment, or healthcare operations to the following people:

NAME:	RELATIONSHIP:
_______________________________________	____
_______________________________________	____
_______________________________________	____
_______________________________________	____

Signature ____ **Date** ___________________________

Printed Name ____

Relationship (If not the patient) ____

Patient Name: ___________________________ Date of Birth: __________________________

HIPAA NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires all medical, dental, and other individually identifiable protected health information (PHI) be kept confidential when used or disclosed in any form (electronic, written, or oral). HIPAA gives you, the patient, significant rights to understand and control your PHI usage. HIPAA penalizes covered entities that misuse PHI.

Protected health information (PHI) is information that identifies you such as your name, age, date of birth, medical conditions, past medical history, future treatments, and more. This Notice of Privacy Practices (NPP) describes how we may utilize your PHI to carry out treatment, payment, and health care operations (TPO), and other purposes that are permitted or required by law. It also describes your rights to access and control your PHI.

Uses and Disclosures of Protected Health Information (PHI)

Your PHI may be used and disclosed by your physician, our office staff, other providers, your insurance company, or other third parties involved in your treatment. Use and disclosure of your PHI ensures you receive health services, ensures payment can be made for your medical expenses, supports operations of the practice, and may be required by law in some cases.

- Treatment: We will use and disclose your PHI as necessary for coordination and management of your care.
- Payment: Your PHI will be used, as needed, to obtain payment and authorization for health care services from entities such as insurance companies, health savings plans, attorneys, and other financial institutions.
- Healthcare Operations: We may use PHI as necessary to support the business activities of the practice such as quality assessment and employee training activities. We may use or disclose your PHI when contacting you with appointment information via mail, email, or phone. *Please inform us if you would prefer that we call or contact you at another telephone number or location.*
- Required Uses and Disclosures: Under the law, we must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with HIPAA requirements. Your PHI may be utilized without your authorization for: public health issues, communicable diseases, health oversight, abuse or neglect, and Food and Drug Administration requirements; legal proceedings, law enforcement, criminal activity, military activity, or national security; coroners, funeral directors, or organ donation; research; worker's compensation; and for any other use as required by law. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorizations.

Your Rights

The following statements describe your rights regarding your PHI. Under HIPAA you have the right:

- To inspect and copy your PHI, except for: psychotherapy notes; PHI compiled for use of civil, criminal, or administrative action or proceeding, and other PHI that is prohibited by law.
- To request a restriction of your PHI. You may ask us not to use or disclose any of your PHI for TPO purposes.
- To request that your PHI not be disclosed to family or friends involved in your care, or for notification purposes outlined in this NPP. Your request must state the specific restrictions of PHI and who the restrictions apply to.
- To request to receive confidential communications from us by alternative means or locations.
- To obtain a paper copy of this notice from us, even if you have agreed to accept this notice alternatively (i.e. electronically).
- To have your physician amend your PHI. If we deny your amendment request, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- To receive an account of certain PHI disclosures we have made, if any.
- Your physician is not required to agree to your requested restrictions. If your physician believes it is in your best interest to permit use and disclosure of your PHI, it will not be restricted. You then have the right to use another healthcare professional.
- We reserve the right to change the terms of this NPP and will inform you of any changes. You then have the right to object to or withdraw this NPP.

Complaints

If you believe your HIPAA rights have been violated, please contact us or the Secretary of Health and Human Services. You may file a complaint with us by notifying the HIPAA privacy officer at our office and main telephone number. We will not retaliate against you for filing a complaint.

By signing below, you agree that you have reviewed the above Privacy Policy and understand your patient rights.

____ _______________________________

Patient Signature **Date**